

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____
Patient's SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZED JESSICA B. GILLOOLY, PhD., MFT TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Jessica B. Gillooly, PhD., MFT to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
- I give JESSICA B. GILLOOLY, PhD., MFT permission to treat me in an open room where other clients are also being treated, ie, group or couples therapy. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with you at any time in private, I will provide a room for these conversations.
- By signing this form you are giving JESSICA B. GILLOOLY, PhD., MFT permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke the AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that I have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the office of JESSICA B. GILLOOLY, PhD., MFT. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by Jessica B. Gillooly, PhD., MFT.

This AUTHORIZATION is requested by **the Office of Jessica B. Gillooly, PhD., MFT** for its own use/disclosure of PHI.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **Jessica B. Gillooly, PhD., MFT** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

- A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print name of Client

Signature of Client

Date

Signature of Personal Representative

Description of Representative's Authority to Act for Client